BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **FELIPE A. CECENA, M.D.** Holder of License No. **15243** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0721A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 12, 2007. Felipe A. Cecena, M.D., ("Respondent") appeared before the Board with legal counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 15243 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0721A after receiving Respondent's July 2005 license renewal application wherein he answered in the affirmative the question regarding whether his hospital privileges had been revoked, denied, suspended, or restricted since his last renewal. Subsequent to receiving Respondent's application the Board also received a report from a hospital that Respondent's privileges were suspended for his failure to adequately evaluate a seventy-year-old hospitalized female patient ("ES").

4. ES was admitted to the hospital at approximately 8:00 p.m. on October 23, 2003 with severe respiratory distress. ES was intubated and a workup revealed a non Q wave myocardial infarction. ES spent eleven hours in the emergency department before being admitted

to the Intensive Care Unit ("ICU"). While in the ICU ES became hypotensive and was placed on Dopamine and later switched to Levophed. At 8:15 a.m. October 24, 2003 Respondent's partner, Dr. A, presented to see ES and ordered an emergent transfer to another facility for a heart catheterization. ES's blood pressure pre-procedure on Levophed was 165/65 with a pulse of 104. Between 10:00 a.m. and 11:30 a.m. Dr. A completed the heart catheterization and stented the right coronary artery. ES was given Angiomax, Integrilin and Plavix. ES's post-procedure blood pressure was 82/38 with a pulse of 97.

5. ES was transferred to the ICU and from 12:50 p.m. to 4:00 p.m. her vital signs stabilized and she was weaned off the Levophed. At 4:00 p.m. ES's blood pressure was 142/56 and her pulse was 90. At 6:30 p.m. ES's blood pressure started to decrease again (112/36) and her pulse increased to 124. The nursing staff restarted the Levophed. By 7:20 p.m. ES's blood pressure had dropped further to 80/47 and her pulse was 141. Nursing staff called Dr. A and informed him ES was hypotensive, tachycardic, and had an expanding groin hematoma. Dr. A ordered lab work and informed nursing staff that Respondent was on call for him. Nursing staff then called Respondent and told him ES was hypotensive, tachycardic, and had an expanding groin hematoma post heart catheterization. Respondent ordered nursing staff to contact vascular surgery for a consult, but all three surgeons who were contacted declined to see ES. Respondent then contacted another physician who agreed to have ES transferred to Arizona Heart Hospital for emergency surgery. There is a large time gap in the medical record between Respondent's first orders for vascular surgery consult and the transfer order to Arizona Heart Hospital written at 10:50 p.m. by the hospital's emergency room physician who saw ES at nursing staff request due to her persistent hypotension. ES's hypotension led to a full-blown code at 10:15 p.m. Respondent did not go to the hospital to see ES at any time.

6. ES died shortly after arriving at Arizona Heart Hospital. Respondent added an un-timed and undated entry to ES's chart after she died. During an interview with Board Staff

Respondent stated he did not go into the hospital because he was ill. This is in direct contradiction to Respondent's explanation to the hospital. Respondent told Board Staff he falsely told the hospital he was involved in another procedure at another facility and could not go in to see ES.

7. Respondent maintained he was not briefed on ES's condition when her care was transferred to him and, when informed of her condition by the nurses, he ordered she be seen by a vascular surgeon because only such a surgeon could provide the care ES needed. Respondent maintained he never abandoned ES and arranged for her transfer to Arizona Heart Hospital and arranged for a vascular surgeon at that facility. At the time of ES's procedure Respondent was one of three cardiologists in his group who shared coverage at two hospitals. When coverage was transferred oral instructions were relayed regarding the name of the patient and the conditions the patient had. In Dr. A's cath report he dictated at 12:03 p.m. that "[Respondent] will follow [ES] in the ICU." Respondent maintained he was not aware of this note or of ES until he was called by the nurses after 7:00 p.m.

8. Respondent claimed he did not go in to see ES at this point because he was very ill with food poisoning and was at home very sick. Although was no back-up physician in place to cover for Respondent, he could have called Dr. A and told him he was unable to cover and that ES was crashing, but he did not. Respondent maintained he did not because he knew Dr. A had refused to see ES three times during the afternoon when he was responsible for her care. At some point after the incident with ES, Respondent was unable to come to an acceptable coverage arrangement with his group and he resigned.

9. When Respondent first explained to the hospital why he did not go in to see ES he told them he was otherwise occupied in the catheterization lab at another facility, not that he was sick. Respondent maintained he told them he was occupied because by the time he was able to meet with the hospital they had sent him multiple meeting notices, but he had not received them

and they were very angry because they believed he ignored earlier notices and they would not listen to his explanation. Respondent then met with the Director of his Department who suggested writing a letter to the hospital on Respondent's behalf telling them he was busy in the catheterization lab and could not be at ES's side. Respondent accepted the letter and submitted it to the hospital.

10. The morning after ES's death Respondent countersigned all the nursing notes and then inserted an un-timed and undated physician order in the chart transferring ES to Arizona Heart Hospital admitted by Respondent and the physician who agreed to accept her. Respondent stated there were a lot of things missing in ES's chart and he reviewed the Orders and his order transferring ES was not there, so he added it.

11. Respondent believes the ultimate cause of ES's death was blood loss, exsanguination, or significant anemia that contributed to her cardiac problems. Respondent believed ES would be transferred immediately by helicopter, but the helicopter was unavailable and her transfer was delayed for four hours. During the four hour period from when Respondent was first contacted about ES until her transfer Respondent was unaware ES was bleeding from a hematoma on the contralateral side from where the cardiac catheterization was performed. Respondent believed ES was bleeding from the procedure side. Respondent's failure to present to the hospital and examine ES deprived him of the knowledge that she was bleeding from the opposite side and that the intervention the nurses were trying was not working.

12. The standard of care required Respondent to present to the hospital and evaluate a critically ill patient. If Respondent was physically unable to present to the hospital the standard of care required he contact the physician he was covering for and inform him he was too ill to care for the patient.

13. Respondent deviated from the standard of care when he did not present to the hospital to evaluate ES. Respondent deviated from the standard of care because, if he was too ill to present, he did not contact the physician he was covering for and apprise him of the situation.

14. Respondent's failure deprived ES of the chance to survive.

15. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's record for ES does not meet this standard.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution"); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for failing to timely see a critically ill patient, for making false and misleading statements in the medical record and to the hospital, and for inadequate medical records.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Respondent shall obtain 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in ethics. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license. The probation will terminate when Respondent supplies proof of course completion that is satisfactory to Board Staff.

b. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

c. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty

(30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 8th day of June 2007.

ARIZONA MEDICAL BOARD
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STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of June, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 8th day of June, 2007, to:

Stephen Myers
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3003 North Central Avenue – Suite 1900
Phoenix, Arizona 85012-2910

Felipe A. Cecena, M.D.
Address of Record